The Department of Medical Assistance Services
Community Psychiatric Support and Treatment (CPST) – School Setting

1. Definitions

Refer to Appendix A and the Telehealth Supplement for definition of terms used in this Appendix. The following definitions are specific to Community Psychiatric Support Teams (CPST).

School Setting (8VAC20-132-10): means a publicly funded institution where students are enrolled for all or a majority of the instructional day and those students are reported in fall membership at the institution or (§ 22.1-19) a privately funded institution recognized by Virginia Council for Private Education (VCPE) through the school's accreditation with a VCPE approved accrediting association.

Affiliated means any entity or property in which a DMAS enrolled provider has a direct or indirect ownership interest of 5 percent or more, or any management, partnership or control of an entity.

Comprehensive Assessment of Needs and Strengths (CANS Lifetime): CANS Lifetime is a multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services for both adults and youth. The CANS Lifetime was developed from a communication perspective to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.

Licensed Mental Health Professional or **LMHP** means the same as defined in 12VAC35-105-20. LMHPs must be a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, licensed behavior analyst, or licensed psychiatric/mental health nurse practitioner. LMHPs are fully licensed to practice independently.

Licensed Mental Health Professional-type or LMHP-type means A LMHP-Resident in Counseling (LMHP-R), LMHP-Resident in Psychology (LMHP-RP) or LMHP-Supervisee in Social Work (LMHP-S). LMHP residents/supervisees shall only perform activities where indicated as allowed by a LMHP-R, LMHP-RP or LMHP-S.

Early Serious Mental Illness (Adults): The initial onset of a diagnosable mental, behavioral, or emotional disorder that significantly impacts an individual's functioning, potentially hindering their ability to achieve expected levels of interpersonal, academic or occupational success.

Serious Mental Illness (Adults): means an individual over the age of 18, having within the past year, a diagnosable mental, behavioral, or emotional disorder that substantially interferes with the individual's life and ability to function.

Serious Emotional Disturbance (Youth): someone under the age of 18 having (within the past year) a diagnosable mental, behavioral, or emotional disorder that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities.

Supervision is relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of a staff person. It is a structured professional relationship where a more experienced mental health professional (the supervisor) oversees the work of a less experienced or newer professional or paraprofessional (the supervisee), with the primary goal of fostering growth and learning.

1. Core Functions of Supervision

Supervision serves three primary functions:

Educational/Clinical Function: Supervisors are responsible for imparting knowledge, refining skills, and promoting professional development. The supervisor teaches therapeutic skills and helps the staff and

collaborative behavioral health team develop self-awareness to better the therapeutic interactions with individuals participating in services.

Regulatory Compliance/Case Oversight Function: Objectives of the agency/organization's policy and public accountability are transformed into practice standards. This ensures compliance with regulations, documentation requirements, and organizational protocols. The supervisor provides education and oversight as part of a collaborative behavioral health service to guide treatment planning and monitor outcomes.

Supportive Function: Daily work with individuals experiencing symptoms of a mental illness can be inherently distressing, so a key aspect of supervision is often helping staff to learn to manage the emotional demands of the work. Supervision has been found to increase provider competence and decrease stress.

2. Key Components of Supervision

Supervision encompasses multiple roles where the supervisors are a teacher, coach, consultant, mentor, evaluator, and administrator; the supervisor provides support, encouragement, and education to staff while addressing an array of psychological, interpersonal, physical, and spiritual needs of the individual.

The process involves regular meetings between supervisor and supervisee to discuss individual cases, treatment strategies, ethical considerations, professional development needs, and service decision-making. Supervision makes sure that the care provided meets the standards in terms of safety and effectiveness, and that any concerns related to the individual participating in services are addressed.

Part-time employment (PTE) means any staff person that averages 29 hours or less of work per week.

In-Person means physically in-person with the individual/caregiver.

Face-to-face means the service component may be delivered via telemedicine (simultaneous audio/visual) if clinically appropriate.

2. Service Definition/Critical Features

Community Psychiatric Support and Treatment (CPST) is a multi-component, team-based service for youth in a school setting that recognizes the widespread impact of trauma and prioritizes safety, trustworthiness, and collaboration. CPST consists of assessment, counseling, therapeutic interventions, care coordination and crisis and functional supports, all delivered through a trauma-informed lens. Services are delivered in collaboration with the youth, their family and the school, emphasizing goal-directed, solution-focused interventions aligned with the youth's Individual Service Plan (ISP) and, for youth with an Individualized Education Program (IEP), the youth's IEP. Interventions support the development of natural supports, promote emotional regulation, and help youth achieve identified person-centered goals related to their emotional, social, and personal growth. These individualized, trauma-informed interventions are grounded in principles of safety, choice, collaboration, and cultural humility and are designed to assist the individual in achieving stability and functional improvement in daily living, family/caregiver and interpersonal relationships, and personal recovery and resilience. CPST services prioritize the individual's inherent strengths and ability to succeed in a school setting while recognizing that trauma responses are normal adaptations to abnormal circumstances. Services support individuals in identifying and accessing needed resources, demonstrating improvement in school, and family/caregiver functioning, and enhancing the family/caregiver's capacity to provide supportive environments that promote healing and successful integration into the identified school setting.

The service location in general shall be the school setting. CPST-School Setting may be provided in the home as specifically identified in the individual's ISP goals and objectives and goals and objectives are specifically related to improving the youth's functioning in the school setting. The service location must be documented on the individual's ISP and must be associated with a specific goal or objective.

Youth shall be served within the context of the family/caregiver relationships to assure that family/caregiver dynamics are addressed and are a primary part of the treatment plan and approach. The family/caregiver or other legally authorized representatives of youth participating in the service are expected to have a role in the

youth's treatment. The plan for family/caregiver involvement in treatment must be included in the ISP and documented in progress notes.

CPST is delivered by a collaborative team of licensed mental health professionals and trained paraprofessionals, under collaborative behavioral health services (as defined in § 54.1-3500). CPST services include medically necessary, evidence-based interventions tailored to the unique needs of each youth that emphasize physical and emotional safety and shared decision-making. The licensed mental health professional conducts assessments, develops the ISP and collaborates with the IEP team/school team, and oversees direct service delivery by qualified team members. Care coordination ensures communication among school staff, families, and community providers to support continuity of care.

The long-term goal of CPST is to require minimal ongoing professional intervention and optimal school integration. CPST is not intended to be an indefinite, ongoing service.

2.1 Goals of CPST School-Setting

The primary focus of CPST in a school-setting must include key developmental needs and protective factors such as:

1. Developing independent coping strategies and self-care practices
2. Supporting executive functioning skills (planning, organization, impulse control)
3. Developing problem-solving capabilities for life challenges
4. Developing prosocial peer relationships,
5. Creating opportunities for meaningful participation in school community
6. Restoration/stabilization of positive family/caregiver relationships,
7. Building positive relationships with trusted adults in the school
8. Teaching concrete life skills (communication, stress management, decision-making)

The goals of CPST school setting services include:

1. Restoration to a youth's best level of functioning by restoring the youth to their best developmental trajectory;
2. To ameliorate, restore and enhance the youth's functional skills necessary to:
    a. develop and maintain positive interpersonal relationships with peers, school staff and family;
    b. practice and implement skills that contribute to increased school community connectedness and social belonging;
    c. improve the use of daily living skills including, school attendance, behavior that contributes to loss of class time or school directed discipline, and coping strategies
    d. facilitate the youth's ability to participate fully and successfully in the school environment and the broader community.
    e. enhance the youth's functional stability and resilience and strengthen the family's capacity to assist the youth in achieving success within both the school setting and the broader community.

CPST is delivered by two or more members of a team consisting of professional and paraprofessional staff.

2.2 CPST Teams

CPST is delivered by two or more members of a team consisting of professional and paraprofessional staff.

Tier One: Must include a Licensed Mental Health Professional and may also include an additional LMHP or LMHP-R, LMHP-RP, LMHP-S, QMHP or QMHP-T.

Team	Supervisor	Staff Type	Staff Type
CPST Tier One Team #1	LMHP Clinical Supervisor	LMHP	
CPST Tier One Team #2	LMHP Clinical Supervisor	LMHP-R, LMHP-S, LMHP-RP	
CPST Tier One Team #3	LMHP Clinical Supervisor (provides all service	QMHP or QMHP-T	

	components that require an LMHP-type)		
CPST Tier One Team #4	LMHP Clinical Supervisor	LMHP-R, LMHP-S, LMHP-RP	QMHP or QMHP-T

Tier Two: Must include a LMHP and an additional team member who is eligible to provide Tier One services. Tier Two may include QMHP-T or Behavioral Health Technician to provide rehabilitation skills practice.

Team	**Supervisor**	**Staff Type**	**Staff Type**	**Staff Type**
CPST Tier One Team #1	LMHP Clinical Supervisor	LMHP		
CPST Tier One Team #2	LMHP Clinical Supervisor	LMHP-R, LMHP-S, LMHP-RP		
CPST Tier Two Team #3	LMHP Clinical Supervisor (provides all service components that require an LMHP-type)	QMHP or QMHP-T		
CPST Tier Two Team #4	LMHP Clinical Supervisor	LMHP-R, LMHP-S, LMHP-RP	QMHP or QMHP-T	
CPST Tier Two Team #5	LMHP Clinical Supervisor	LMHP-R, LMHP-S, LMHP-RP (provides all service components that require an LMHP-Type, QMHP or QMHP-T	BHT	
CPST Tier Two Team #6	LMHP Clinical Supervisor (provides all service components that require an LMHP-type)	QMHP or QMHP-T	BHT	
CPST Tier Two Team #7	LMHP Clinical Supervisor	LMHP-R, LMHP-S, LMHP-RP	QMHP or QMHP-T	BHT

3. Required Evidence-Based Practices

Use of trauma-informed and evidence-based principles, practices, and protocols will be required for all agencies providing Tier 1 and Tier 2 CPST. All providers shall incorporate appropriate research-based programming for both treatment planning and service delivery.

- Evidence based *protocols* are detailed procedural specifications of indicated treatments
- Evidence based *principles* are modular alternatives to evidence-based protocols that are drawn from supported protocols, but flexibly and dynamically applied.
- Evidence based *practices* are general practices that have been shown to increase quality of care across behavioral health conditions and approaches, including routine outcome monitoring, feedback, supervision, and quality improvement.

- Evidence based *policies* include mandates, differential reimbursement, or development of core competencies.

3.1 Measurement Based Care

3.1.1 CANS Lifetime

The CANS Lifetime assessment serves as the primary assessment for Level of Need (LON) placement and longer-term treatment planning and monitoring. The CANS must be completed every twelve months, at a minimum, for individuals receiving CPST to support treatment planning, level of need updates, monitoring outcomes, and to facilitate communication and linkages between the assessment process and the design of the ISP including the application of evidence-based practices.

3.1.2 Other Clinical Assessments to Support Measurement Based Care

To better inform treatment approaches and the monitoring of progress, in addition to the CANS Lifetime assessment, providers are strongly encouraged to utilize ongoing clinical assessments and symptom checklists.

For adults, the following assessments are recommended:

1. Ask Suicide-Screening Questions (ASQ)
2. Columbia Suicide Severity Rating Scale (C-SSRS)
3. Daily Living Activities-20 (DLA-20)
4. Patient Health Questionnaire (PHQ-9)
5. Post-Traumatic Stress Disorder (PTSD) Scale
6. World Health Organization Disability Assessment Schedule (WHODAS)

For youth, the following assessments are recommended:

1. Ages and Stages Questionnaire (ASQ: SE-2)
2. Alabama Parenting Questionnaire (APQ-SR and corporal punishment module)
3. Ask Suicide-Screening Questions (ASQ)
4. Brief Child Abuse Potential Inventory (BCAP)
5. Child PTSD Symptom Scale for DSM5 (CPSS-5)
6. Client Satisfaction Questionnaire (CSQ-8)
7. Clinical Global Impression Scale (CGI)
8. Columbia Suicide Severity Rating Scale (C-SSRS)
9. Conflict Tactics Scale (CTS)
10. Family Environment Scale (FES)
11. Individual Goal Achievement Rating Scale (IGAR)
12. Parenting Stress Index Short Form (PSI-36)
13. Pediatric Symptom Checklist (PSC)
14. Strengths and Difficulties Questionnaire (SDQ)
15. World Health Organization Disability Assessment Schedule (WHODAS)

3.2 Referral to Standalone EBPs

Individuals must be referred to and their needs assessed for any clinically appropriate standalone EBPs of which they may meet admission criteria, prior to the authorization of CPST services, regardless of whether the agency completing the CANS Lifetime offers the EBP. Services that individuals and families must be referred to and offered, if they meet admission criteria, prior to the authorization of CPST include:

- Assertive Community Treatment
- Coordinated Specialty Care
- Functional Family Therapy
- Multisystemic Therapy

All efforts to refer shall be documented should the EBP not be available due to extenuating circumstances such as geographic location, extended wait lists, or does not take allowable forms of insurance.

The individual's MCO must be notified if the CANS Lifetime is completed and results indicate a potential fit for a standalone EBP. CPST providers shall work with MCOs and referral receiving agency to ensure the CANS Lifetime is not repeated if not necessary, proper care coordination occurs, and that all parties are aware of ongoing assessment dates.

If an individual is not making progress in CPST after the authorization period, the individual shall be referred to an appropriate EBP.

3.3 Service Delivery for CPST Populations

3.3.1 Service Delivery- Specific to Youth

For CPST service delivery, all youth serving agencies must meet state requirements for training in Managing and Adapting Practice (MAP). MAP is a modular, flexible approach to guide treatment planning and leverage evidence-based principles for a range of common presenting problems. Training requirements by professional type for CPST-Youth serving agencies are as follows:

1. Each agency must have one LMHP who meets the criteria of MAP Credentialed Therapist.
2. All LMHP-Types who provide services to youth must complete the LMHP MAP curriculum.
3. All QMHPs and QMHP-Ts who provide services to youth must complete the QMHP MAP curriculum.
4. All BHTs who provide services to youth must complete the BHT MAP curriculum.

The statewide training includes mandatory modules for all professional types on the following topics:

1. Anxious Behaviors and Exposure Based Treatments
2. Cognitive Behavioral Approaches to Address Depressive and Withdrawn Behaviors
3. Contingency Management, Community Reinforcement for Co-Occurring Substance Use Disorders
4. Parent Management Training, Managing Hyperactive and Disruptive Behaviors
5. Teacher Training, Managing Hyperactive and Disruptive Behaviors
6. Treating Traumatic Stress in Youth

The statewide requirement for training and application of Managing and Adapting Practice (MAP) does not limit professional staff from providing other appropriate, evidence-based protocols in which they are trained, to meet the needs of CPST clients, particularly as part of the psychotherapy component of CPST. For example, evidence-based protocols such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) would represent an appropriate protocol-based approach that ties together the MAP recommendations for traumatic stress which would include parent training, psychoeducation, cognitive processing, and exposure, all of which are the key components of the TF-CBT protocol.

Clinical best practice guidelines should be maintained and regularly updated in agency policy, particularly for the most common presenting problems to include, Neurodevelopment Disorders, Anxiety Disorders, Trauma- and Stressor-Related Disorders, Depressive Disorders, Disruptive, Impulse-Control and Conduct Disorders and any other disorders commonly treated by the provider. For youth presenting with a mental health disorder, that aligns with an evidence-based treatment approach, that cannot be provided directly through the CPST service structure, CPST providers shall ensure that the EBP options are coordinated through the care coordination component of the service. Application and education on clinical best practice guidelines and evidence-based approaches shall be a priority focus in supervision and other reflective and professional development opportunities offered by the agency to support staff.

All professional types must complete the foundational Youth Mental Health Rehabilitative Supports and Services training. The statewide training includes mandatory modules for all professional types on the following topics:

1. Crisis Skills
2. Fundamentals of SED and youth behaviors/functioning
3. Listening and engagement skills
4. Motivational Interviewing
5. Person centered planning
6. Professional ethics for providing services to youth and families

3.3.2 Service Delivery specific to Adults

For CPST service delivery, all adult serving agencies must meet state requirements for training in Adult Mental Health Rehabilitative Supports and Services. CPST-School Setting may include serving youth between the ages of 18-under 21.

All professional types must complete the foundational Adult Mental Health Rehabilitative Supports and Services training. The statewide training includes mandatory modules for all professional types on the following topics:

1. Crisis Skills
2. Fundamentals of Psychiatric Rehabilitation to include Permanent Supportive Housing
3. Fundamentals of Serious Mental Illness to include Severe and Persistent Mood Disorders
4. Listening and engagement skills
5. Motivational Interviewing
6. Person-centered planning
7. Professional ethics
8. Recovery principles

There are also requirements on topics such as Mood, Psychosis, Trauma, Anxiety and Substance Use wherein the agency has the ability to make choices as it pertains to the specific practices (i.e., Anxiety trainings can include topics such as: anxiety psychoeducation, fear ladder, self-monitoring etc.).

In addition to the required statewide training, LMHPs providing supervision or the assessment and counseling components of CPST must seek training (requirements to be defined by CEP-VA, DBHDS, and DMAS) in at least one of the following approaches based on the needs of the population served:

1. Cognitive Behavioral Therapy for Anxiety
2. Cognitive Behavioral Therapy for Mood
3. Cognitive Behavioral Therapy for Personality Disorders
4. Cognitive Behavioral Therapy for Psychosis (CBT-p)
5. Cognitive Behavioral Therapy for Trauma

Clinical best practice guidelines shall be maintained and regularly updated in agency policy, particularly for the most common presenting problems to include Schizophrenia Spectrum Disorders (including best practices for first episode psychosis), Bipolar I and II, Major Depression, and Post-Traumatic Stress Disorder (PTSD). Based on the population served, expertise and clinical training in treating Personality Disorders and Anxiety Disorders is also recommended. Application and education on clinical best practice guidelines and evidence-based approaches shall be a priority focus in supervision and other reflective and professional development opportunities offered by the agency to staff.

Other relevant and suggested EBPs are as follows:

1. Acceptance and Commitment Therapy
2. Brief Solution Focused Therapy
3. Collaborative Assessment and Management of Suicidality
4. Cognitive Processing Therapy
5. Dialectical Behavioral Therapy
6. Eye Movement Desensitization and Reprocessing
7. Exposure and Response Prevention
8. Family Focused Therapy
9. Interpersonal Social Rhythm Therapy
10. Mindfulness Based Cognitive Therapy
11. Prolonged Exposure
12. Rational Emotive Behavioral Therapy
13. Seeking Safety

3.3.3 Service Delivery - Transition Age Youth

Coordinated Specialty Care (CSC) is a recovery-oriented treatment program for people with first episode psychosis (FEP). CSC promotes shared decision making and uses a team of specialists who work with the individual served to create a personal treatment plan. The specialists offer psychotherapy, medication management geared to individuals with FEP, family education and support, case management, and work or education support, depending on the individual's needs and preferences. The individual and the team work together to make treatment decisions, involving family members as much as possible. The goal is to link the individual with a CSC team as soon as possible after psychotic symptoms begin.

CPST service delivery by agencies working with transition age youth (between the ages of 16-25) shall be evaluated on an individual basis to determine placement in Youth or Adult services. If an individual began in youth services prior to their eighteenth birthday, the agency shall provide the individual with the opportunity to remain in their established services if it is clinically appropriate and in the best interest of the individual. Providers of CPST services for transition age youth are required to complete all trainings for adults and youth as indicated above.

3.4 Required Documentation

Annually, providers must submit documentation to the Center for Evidence-Based Partnerships (CEP-VA) at Virginia Commonwealth University (VCU) demonstrating compliance with statewide training requirements and clinical best practice policies.

4. Required Service Oversight and Supervision

4.1 CPST Team

The CPST team employs a multidisciplinary model, with both professional and paraprofessional staff. The professional staff include LMHPs, LMHP-Rs, LMHP-RPs or LMHP-Ss and paraprofessional staff include staff meeting the qualifications of a QMHP, QMHP-T and/or BHT.

4.2 Agency Oversight

1. CPST providers shall have a full-time Clinical Director who holds a Virginia license from the Department of Health Professions that qualifies them as a LMHP.
2. A Clinical Director may, at a maximum, supervise nine staff total across all agencies employed.

4.3 LMHP Oversight

1. All LMHPs, including the Clinical Director and LMHP Clinical Supervisors, must hold a Virginia License from the Virginia Department of Health Professions that qualifies them as a LMHP
2. All LMHPs shall have the ability to provide in-person services.
3. All CPST services shall be recommended and overseen by a LMHP Clinical Supervisor (Clinical Director may act as the LMHP Clinical Supervisor).
4. All staff must provide services under the direct supervision of a LMHP.
5. A senior-level LMHP (may be the Clinical Director or another LMHP), with a minimum of two years experience working with individuals with a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED), trained in working with individuals with SMI or SED, shall be available to all staff 24 hours a day, seven days a week for consultation on an as needed basis.
6. The LMHP, LMHP-R, LMHP-S, or LMHP-RP providing the assessment, treatment planning and psychotherapy components of CPST must provide in-person services to the individual at least every 90-calendar days.

4.4 Collaborative Behavioral Health Services/Supervision of team members

1. A LMHP Clinical Supervisor must facilitate a weekly face-to-face team meeting to ensure that the planned interventions are provided; to allow staff to briefly discuss the status of all individuals receiving services; problem-solve emerging issues; and plan approaches to intervene and prevent crises. This

may be coordinated or integrated into group supervision hours (See Section 4.5 below). Additional supervision or support may be provided as a group or with individual team members to address specific concerns or challenges during staff supervision.

2. The LMHP may choose to have a QMHP assist with gathering information/documentation for assessment and treatment planning activities. However, the LMHP is ultimately responsible for the quality, completeness, accuracy of the entire assessment, diagnosis and ISP. The LMHP is ultimately responsible for the service goals and outcomes defined in the ISP.
3. It is the responsibility of the LMHP Clinical Supervisor and the Clinical Director to ensure that any non-licensed staff practice within the scope of their education, training, and expertise and are not providing any services that require licensure.

4.5 Supervision of individual staff

1. Supervision of staff must be provided by a LMHP Clinical Supervisor employed by the DBHDS licensed CPST agency.
2. LMHP Clinical Supervisor may, at a maximum, supervise nine staff total across all agencies employed (including LMHP-types, QMHPs, and BHTs).
3. Minimum supervision for all staff shall include no less than one hour of individual supervision per calendar month.
4. The remaining hours of required supervision may be in a group setting with no more than nine staff.
5. At least half of all required staff supervision must be provided in-person.
6. Supervision must be provided at least weekly for non-licensed staff (including LMHP-R, LMHP-S, and LMHP-RPs) and at least monthly for LMHPs.
7. Documentation of staff supervision must be maintained in the staff employment records held by the DBHDS licensed CPST agency.
    a. For DBHDS-licensed entities, the provider must provide ongoing supervision of staff consistent with the requirements of 12VAC35-105 in addition to as outlined here.

4.5.1 Supervision of LMHPs

LMHPs shall receive at least one hour per calendar month of individual supervision by the agency's Clinical Director. If an agency employs only a single LMHP who serves as the Clinical Director, this is not required.

4.5.2 Supervision of LMHP-R, LMHP-RP or LMHP-Ss

1. LMHP-Rs, LMHP-RPs and LMHP-Ss shall receive regularly scheduled supervision in accordance with requirements established by the practitioner's professional licensing board.
    a. Official documentation from the Department of Health Professions of the board approved supervision and supervisor must be maintained in the staff employment record.
    b. Official documentation of the supervision sessions must be maintained in the staff employment record.
2. Full-time LMHP-Rs, LMHP-RPs, and LMHP-Ss must receive a minimum of four hours of supervision per calendar month by the agency LMHP Clinical Supervisor.
3. Part-time LMHP-Rs, LMHP-RPs, and LMHP-Ss must receive a minimum amount of supervision by the agency LMHP Clinical Supervisor per the following:
    a. Part-time staff with caseloads between one to five must receive a minimum of one hour of supervision per calendar month
    b. Part-time staff with caseloads between six to ten must receive a minimum of two hours of supervision per calendar month
    c. Part-time staff with caseloads between 11-14 must receive a minimum of four hours of supervision per calendar month.

4.5.3 Supervision of QMHPs, QMHP-Ts, BHTs

1. QMHP, QMHP-T and BHT staff shall practice under the supervision of a LMHP.

2. Full-Time QMHPs, QMHP-Ts, BHTs must receive a minimum of four hours of supervision per calendar month by the agency LMHP clinical supervisor.
3. Part-time staff with caseloads between one to five must receive a minimum of one hour of supervision per calendar month by the agency LMHP Clinical Supervisor.
4. Part-time staff with caseloads between six to ten must receive a minimum of two hours of supervision per calendar month by the LMHP Clinical Supervisor.
5. Part-time staff with caseloads between 11-14 must receive a minimum of four hours of supervision per calendar month by the LMHP Clinical Supervisor.

4.6 Staff Caseloads

1. Appropriate caseloads will vary based on team composition and Level of Need and shall be monitored by LMHP Clinical Supervisors or Agency Clinical Director.
2. In general, a full-time, non-licensed team member providing Tier One services should not support more than 20 individuals participating in services at a time.
3. In general, a full-time, non-licensed team member providing Tier Two services should not support more than 8 individuals participating in services at a time.
4. Full-time staff: a blended caseload (combination of Tier One and Tier Two individuals) shall be calculated as: (# Tier Two Clients * 2.5) + (# Tier One Clients) = Caseload, not to exceed 20.
5. In general, a part-time, non-licensed team member providing Tier One services should not support more than 14 individuals participating in services at a time.
6. In general, a part-time, non-licensed team member providing Tier Two services should not support more than 6 individuals participating in services at a time.
7. Part-time staff: a blended caseload (combination of Tier One and Tier Two individuals) shall be calculated as: (# Tier Two Clients * 2.33) + (# Tier One Clients) = Caseload, not to exceed 14.
8. Part-time staff caseload limits are determined by how many hours the part-time staff is employed to work each week. The caseload may not exceed 14 for Tier One and 6 for Tier Two and must be in proportion to the amount of hours the staff person works in a week.
    a. Tier One caseload maximum limit is determined as # of hours worked (x) 0.5 and rounded to the nearest whole number.
    b. Tier Two caseload maximum limit is determined as # of hours worked (x) 0.2 and rounded to the nearest whole number.
9. The CPST provider must keep an ongoing formal log of each team member's caseload. An average over a six-month period shall be used to demonstrate compliance with caseload limits.
10. No individual non-licensed staff may bill more than 504 CPST units in any calendar month (across all agencies in which they are employed).
11. Agencies must ensure they have sufficient clinical (Licensed or License-Eligible) capacity to offer the psychotherapy service component of CPST as part of an integrated individual service plan when indicated by the clinical presentation and goals of the individual/family/caregiver while also meeting all supervision requirements.

Full-time employee (FTE) Professional Type	**Required supervisor and minimum hours**	**Maximum number of employees supervised across all agencies employed**	**Caseload requirements**
LMHP Clinical Director	None	May supervise up to nine staff.	Not applicable
LMHP Clinical Supervisor	must be supervised - one hour per calendar month by agency LMHP Clinical Director	May supervise up to nine staff.	Not applicable

LMHP – direct care team member	must be supervised - one hour per calendar month by agency LMHP Clinical Supervisor	Not applicable	Individual consideration
LMHP-R, LMHP-S, LMHP-RP, QMHP, QMHP-T or BHT	must be supervised - 4 hours per calendar month by agency LMHP Clinical supervisor	None	A maximum of: Tier One: 20 individuals Tier Two: eight individuals Combined caseload not to exceed 20 individuals.

Part-time employee Professional Type	**Required supervisor and minimum hours**	**Maximum number of employees supervised across all agencies employed**	**Caseload requirements**
LMHP Clinical Supervisor	must be supervised - one hour per calendar month by agency LMHP Clinical supervisor	May supervise a maximum of nine staff and number of staff shall be in proportion to the amount of hours the LMHP Clinical Supervisor works in a week in order to meet the needs of the supervisees.	Not applicable
LMHP-R, LMHP-S, LMHP-RP, QMHP, QMHP-T or BHT	Caseload one to five: a minimum of one hour of supervision per calendar month by agency LMHP Clinical supervisor Caseload six to ten: a minimum of two hours of supervision per calendar month by agency LMHP Clinical supervisor Caseload 11-14: a minimum of four hours of supervision per calendar month by agency LMHP Clinical supervisor	None	A maximum of: Tier One: 14 individuals Tier Two: six individuals Combined caseload not to exceed 14 individuals.

5 Required Service Components

5.1 Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime)

Prior to starting services, a CANS Lifetime must be completed to include a comprehensive assessment of the individual's treatment needs, identification of a Level of Need and differential service identification and that the individual meets the admission criteria for the recommended service (s).

Assessment means the in-person interaction in which the provider obtains information from the individual and family/caregivers, as appropriate, about the individual's current mental health status and symptoms as well as the history of the severity, intensity and duration of symptoms associated with a mental illness and behavioral and emotional issues and diagnosis of mental health conditions. Assessment includes assisting the individual and family/ caregivers, as appropriate with identifying strengths and needs, resources and natural supports used in developing individualized goals and objectives to address functional deficits associated with their mental illness.

1. Prior to starting services, a comprehensive and age-appropriate behavioral health assessment inclusive of the Virginia's CANS Lifetime must be completed, in-person to determine medical necessity for the service and to support a service authorization for Tier One or Tier Two Services.
2. The assessment shall be conducted by a LMHP, LMHP-R, LMHP-RP or LMHP-S in person with the individual in the individual's home or another location of the individual's/family/caregiver's choice. Assessments completed by a LMHP-R, LMHP-RP or LMHP-S require a LMHP review and co-signature.
3. The LMHP, LMHP-R, LMHP-RP or LMHP-S completing the assessment must be certified to administer the CANS Lifetime.
4. The CANS Lifetime must be provided on an individual basis with team member(s) providing services with one individual.
5. Assessments for adults and youth, inclusive of the CANS Lifetime, shall be performed at a minimum once every 365 days until discharge.

5.2 Treatment Planning

Treatment Planning means the development of a person-centered ISP that is specific to the individual's unique treatment needs, developed with the individual, in consultation with the individual's natural supports, as appropriate.

1. Treatment planning shall be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S.
2. CPST services must be incorporated into a person-centered ISP documenting activities and evidence-based interventions to prevent, correct, or ameliorate conditions identified during the initial CANS Lifetime.
3. The ISP is required during the entire duration of services and must be current. (see Chapter IV for requirements).
4. The ISP must be developed in collaboration with the individual and natural supports through a team approach under collaborative behavioral health services.
5. Treatment planning must be provided on an individual basis with team member(s) providing services with one individual and their natural supports.
6. The ISP must be authorized and overseen by an LMHP.
7. At a minimum, the ISP must be signed by:
    a. The individual and the individual's legally authorized representative.
    b. The CPST team members working with the individual; and
    c. The LMHP Clinical Supervisor overseeing the services.
8. Needs identified in the CANS Lifetime must be associated with identified goals and objectives as set forth in the ISP. Subsequent assessments and needs must be reflected in updated ISPs with updated goals and objectives.
    a. ISP Reviews and Updates:
        i. ISPs must be formally reviewed at a minimum of every 90 calendar days or more frequently depending on the individual's needs. The ISP review must be completed face-to-face and include the LMHP Clinical Supervisor, CPST team and the individual/family/caregiver. Refer to Chapter IV for additional guidance and documentation

requirements for the 90-calendar day review as well as additional quarterly review requirements.

ii. The ISP is what directs collaborative behavioral health treatment. The ISP shall be actively utilized with the individual/family/caregiver during each encounter.

iii. Assessing the individual's level of progress and improved functioning may be assessed utilizing a variety of methods including: ratings on standardized assessment tools, checklists, direct observation, role-play, self-report, improved grades, improved attendance at school or work, improved medication adherence, feedback from the individual, family/caregiver, teacher, and other natural supports, and reduced psychiatric hospitalizations, emergency room, and/or residential treatment services utilization.

iv. When it is determined that an individual is making limited to no progress or is not engaged, the LMHP Clinical Supervisor, in collaboration with the CPST team, the individual and the individual's natural supports, must review and update the ISP to increase the possibility that the individual will make progress achieving the identified goals and objectives. If the individual continues to make limited to no progress, the LMHP Clinical Supervisor must consider if a referral to a different service may improve progress.

v. Following initial authorization, if a youth is not progressing and the family/caregiver is not engaged or participating in treatment, the ISP must be updated to assure individual/family/caregiver involvement before reauthorization of services is considered.

9. The service location in general shall be the school setting. CPST-School Setting may be provided in the home as specifically identified in the individual's ISP goals and objectives and goals and objectives are specifically related to improving the youth's functioning in the school setting. The service location must be documented on the individual's ISP and must be associated with a specific goal or objective.

5.3 Crisis Support

Crisis Support means an intervention to assist the individual and their natural supports in developing the capacity to prevent a crisis episode or reduce the severity of a crisis episode. Crisis support includes crisis planning, crisis avoidance and crisis intervention. Crisis support assists the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location. Crisis support also includes the development and ongoing review and update of a crisis management plan to assist the individual and their natural supports with identifying a potential behavioral health crisis and steps to manage the crisis and restore stability and functioning after distress or crisis.

1. Crisis support shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP or QMHP-T.
2. Providers are required to develop with the individual crisis mitigation plans, which shall **not** include use of or referral to Comprehensive Crisis and Transition Services (Mental Health Services Manual, Appendix G).
3. Crisis Support shall be available 24 hours per day, seven days per week, 365 days per year, to provide immediate assistance to the individual experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity.
4. Crisis Supports must be provided on an individual basis with team member(s) providing services with one individual and their natural supports.
5. In-person crisis support must be offered and available 24 hours per day, seven days per week, 365 days per year. The individual's needs and preference shall be the determining factor regarding whether crisis supports are provided in-person, face-to-face (telemedicine), or audio-only.
6. Any use of telemedicine shall be for the clinical benefit of the individual.
7. In-person crisis support must be provided by the CPST provider prior to any referral to a Comprehensive Crisis and Transition Services (Mental Health Services Manual, Appendix G).
8. The use of Comprehensive Crisis and Transition Services will be monitored by the individual's MCO.

5.4 Restorative Life Skills Training

Restorative Life Skills Training means evidence-based therapeutic interventions, designed to decrease symptoms of the mental health diagnosis, restore functional skills of daily living, build natural supports, and

achieve identified person-centered goals and objectives as set forth in the ISP. Restorative Life Skills Training shall be focused on the individual's ability to succeed in the community; and to show improvement in community and home functioning. Encounters occur in community locations, where the person lives, works, attends school or socializes.

CPST include school setting supports if the activities being provided are focused on management of symptoms of mental illness and recovery. CPST team members work with individuals at the school setting to implement appropriate interventions to support an individual's goals as described in the ISP.

1. Restorative life skills training shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP or QMHP-T.
2. Restorative life skills training shall be provided in accordance with the frequency identified in the ISP.
3. At least half of the Restorative life skills units shall be provided in-person.
4. Restorative life skills training may be provided via telemedicine if deemed clinically appropriate and in consultation with the LMHP Clinical Supervisor and individual.
5. Restorative life skills training may be provided in a group if deemed clinically appropriate and in consultation with the LMHP Clinical Supervisor.
    a. The individual to team member ratio shall not exceed:
        - One LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP or QMHP-T to six youth
6. At least half of the Restorative life skills units must be provided individually with one team member per individual receiving the service. The remaining units may be provided in a group as described in #5.
7. Restorative life skills training may be provided via telemedicine if deemed clinically appropriate and in consultation with the LMHP Clinical Supervisor.

5.5 Care Coordination

Care Coordination means consultation, collaboration, and coordination among health providers and others involved in the individual's treatment including collateral contacts to improve the restorative care, identify and access needed activities and supports and align service plans. Activities may include scheduling appointments and meetings to improve care; planning and implementing individualized behavior modification plans; and monitoring treatment and progress with ISP goals. The provider will be asked to explain what care coordination has taken place during treatment as well as in preparation for discharge and step down to lower levels of care with every request for services

1. Care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S or QMHP.
2. Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
3. Care Coordination must be provided on an individual basis with team member(s) providing services with or for one individual.

5.6 Rehabilitation skills practice (Tier Two Only)

Rehabilitation skills practice means practice of skills through the collaborative behavioral health model as identified in the ISP. Activities include rehabilitation interventions and individualized, collaborative, hands-on training to build developmentally appropriate skills. The intent is to promote personal independence and autonomy through the restoration of skills in self-management, symptom management, interpersonal relationships, communication, and problem solving.

1. Rehabilitation skills practice must be provided for all individuals receiving Tier Two CPST services.
2. All Rehabilitation skills practice must be provided in-person with the individual and cannot be provided via telehealth. Family/caregivers may participate through telemedicine while the staff member provides services in-person with the individual.
3. Rehabilitation skills practice must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T or BHT.
4. Rehabilitation skills practice shall be provided in accordance with the frequency identified in the ISP.
5. Rehabilitation skills practice must be provided on an individual basis with a team member providing services with one individual. Rehabilitation skills practice cannot be provided in groups of individuals.

5.7 Additional covered service components

5.7.1 Psychotherapy

Psychotherapy means the application of principles, standards, and methods of the LMHP profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and assist in the recovery from mental, emotional, or behavioral disorders and associated distresses that interfere with mental health. Psychotherapy helps individuals find relief from emotional distress, seek solutions to problems in their lives, and modify ways of thinking and acting that are preventing the individual from working productively and enjoying personal relationships.

1. Psychotherapy must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP acting within their scope of practice.
2. Psychotherapy shall be provided in accordance with the frequency identified in the ISP.
3. Psychotherapy may be provided in a group with multiple youth if deemed clinically appropriate and in consultation with the LMHP Clinical Supervisor. The LMHP, LMHP-S, LMHP-R or LMHP-RP to youth ratio shall not exceed one to six for youth.
4. Psychotherapy may be provided via telemedicine if deemed clinically appropriate and in consultation with the LMHP Clinical Supervisor, the individual and school personnel.

5.8 CPST Service Provision without the Individual Present

Please see each service component sections for information regarding in-person requirements with the following exceptions:

1. As identified in the ISP, services may occur with a family/caregiver or caregiver without the individual present when it is for the clinical benefit of the individual, with the exception of Rehabilitative skills practice, which can only be provided in-person with the individual present.
2. As identified in the ISP, family/caregivers may participate in any service component through telemedicine.

6 Provider Qualification Requirements

CPST providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.

6.1 Department of Behavioral Health and Developmental Services (DBHDS) Licensing Requirements

Prior to rendering CPST-school setting and/or claiming reimbursement providers are required to be:

1. Licensed by DBHDS as a provider of: (to be determined). The DBHDS license must be active and in good standing (conditional or triennial).
2. Enrolled with DMAS with provider type (to be determined) and provider specialty (to be determined).

6.2 DMAS Provider Enrollment (provider type and specialty type)

1. Provider Type: 146 or 456
2. Provider specialty: to be determined

6.3 School Division Requirements

CPST-school setting providers are required to maintain a current Memorandum of Understanding (MOU) with the Virginia public school division or the specific private school recognized by the Virginia Council for Private Education where services are being provided. A MOU must be reviewed and signed annually. A MOU with a Virginia public school division must include all school divisions, school names and addresses where services are provided.

6.4 Accreditation

Providers are required to be accredited 18 months from July 1, 2026 or within 18 months of establishment as a new agency by the Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities

(CARF), Det Norske Veritas (DNV) Healthcare or The Joint Commission (TJC). Providers must submit with their enrollment application, evidence of their initiation of accreditation process or their formal accreditation.

7 CPST-School Setting Medical Necessity Criteria

7.1 Tier One CPST-School Setting Admission Criteria

All of the following must be met:

1. **Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime) Requirements**
    a. Youth must be assessed using the CANS Lifetime tool within 30 days prior to admission.
    b. The level of need for the youth must be assessed at a Level of Need two or three on the CANS Lifetime.
        i. At least two CANS Lifetime domains scoring ≥ two (actionable needs requiring intervention)
    c. Assessment must document specific functional deficits requiring CPST-school setting.

2. **Diagnostic Criteria: must meet a or b**
    a. The youth meets criteria for a primary ICD diagnosis that correlates to a DSM diagnosis or,
    b. A provisional diagnosis as developed by an LMHP, when no definitive diagnosis has been made.
        i. In instances where behavioral health needs have been identified but a diagnosis is not yet known and/or not specified, providers can use an unspecified ICD-10 diagnosis code, such as R69 (illness, unspecified), F99 (mental disorder, not otherwise specified), or an appropriate Z-code (for a time-limited period not to exceed 90 days).
    c. Youth may also have a co-occurring diagnosis of a substance use disorder or developmental disability.

3. **Functional Impairment Criteria: must meet a and b at least one (level of need two) or two (level of need three) additional domains (c-f)**
    The individual is unable to maintain an adequate level of functioning without CPST due to a mental illness as evidenced by moderate impairment in functioning.
    a. Symptom Management – Documentation submitted by the provider must indicate that the individual exhibits moderate impairment in the ability to manage symptoms of mental illness. Examples of moderate impairment include, but are not limited to:
        i. Mental health symptoms often make it harder to do everyday activities and responsibilities
        ii. Has some understanding of their symptoms but is still learning ways to manage them effectively
        iii. Symptoms cause noticeable stress and make some areas of life more challenging
        iv. Has some coping skills but they do not always work well or are not used consistently
        v. Uses some healthy coping strategies but sometimes relies on less helpful ways of managing stress
        vi. Has difficulty when daily routines change or when in new or unfamiliar situations
    b. Academic/Educational Functioning - Documentation submitted by the provider must indicate that the individual exhibits moderate impairment in the ability to manage symptoms of mental illness. Examples of moderate impairment include, but are not limited to:
        i. Declining academic performance or chronic academic underachievement
        ii. School absences or tardiness related to mental illness symptoms
        iii. Difficulty completing assignments or participating in classroom activities
        iv. Problems with attention, concentration, or memory affecting learning
        v. Need for special education services or accommodations due to emotional/behavioral needs

In addition to meeting impairment in symptom management (a) and academic/educational functioning (b) above, level of need two requires that the individual meet at least one of the following (c-f).

In addition to meeting impairment in symptom management (a) and academic/educational functioning (b) above, level of need three requires that the individual meet at least two of the following (c-f).

c. Social/Interpersonal Functioning - Documentation submitted by the provider must indicate that the individual exhibits moderate impairment in the ability to manage symptoms of mental illness. Examples of moderate impairment include, but are not limited to:
    i. Difficulty forming or maintaining peer relationships
    ii. Social withdrawal or isolation from classmates and school community
    iii. Conflicts with teachers, school staff, or authority figures
    iv. Inappropriate social behaviors that interfere with school participation
    v. Bullying behaviors (as perpetrator or victim) or social aggression
d. Emotional Regulation - Documentation submitted by the provider must indicate that the individual exhibits moderate impairment in the ability to manage symptoms of mental illness. Examples of moderate impairment include, but are not limited to:
    i. Occasional episodes of intense emotions in school setting
    ii. Difficulty managing anger, frustration, or anxiety in school setting
    iii. Mood lability affecting school performance and relationships
e. Behavioral Functioning - Documentation submitted by the provider must indicate that the individual exhibits moderate impairment in the ability to manage symptoms of mental illness. Examples of moderate impairment include, but are not limited to:
    i. Disruptive classroom behaviors interfering with school setting
    ii. Aggression toward peers, staff, or property in school setting
    iii. School avoidance or refusal behaviors
    iv. Risky or impulsive behaviors compromising safety at school
    v. Violations of school rules requiring disciplinary action
f. Family/Caregiver Relationships - Documentation submitted by the provider must indicate that the individual exhibits moderate impairment in the ability to manage symptoms of mental illness. Examples of moderate impairment include, but are not limited to:
    i. Conflicts with family/caregivers affecting school performance
    ii. Family instability impacting youth’s school functioning
    iii. Caregiver struggles to support youth's educational needs due to mental health concerns
    iv. Family trauma requiring coordinated intervention

4. Intensity of Service Criteria:

a. Youth requires at least **three** services from the following categories:
    i. Individual therapy/counseling (minimum weekly)
    ii. Family therapy or caregiver support
    iii. Crisis support and safety planning
    iv. Care coordination between school, home, and community providers
    v. Behavioral support and skill-building interventions
    vi. Trauma-informed therapeutic interventions
b. The interventions necessary to stabilize the individual’s behaviors, symptoms and ability to function requires the frequency, intensity and duration of contact provided by a Tier One CPST provider as evidenced by clinical documentation meeting all of the following:
    i. Supporting the need for weekly intervention for no more than four to six hours per calendar month with a focus on skill building and school integration; **and**
    ii. Demonstrating that standard outpatient therapy (≤ one hour weekly for ≥ three months) was insufficient for stabilization **and**
    iii. Supporting the need for behavioral interventions requiring environmental modification and real-time coaching in the school setting **and**

5. **School-Setting Need Indicators:** must meet at least **one** criteria and provide documentation of the need
    a. Referral from school team due to concerns about academic or social functioning that includes documentation of specific behavioral health related concerns and goals **or**
    b. Current IEP or 504 Plan with goals related to behavioral/emotional functioning

6. **Additional CPST-School Setting criteria:** must meet **all** criteria

There must be:

a. An identified caregiver or legally authorized representative available and willing to participate.
    i. The caregiver(s) shall be a responsible adult who lives in the same household with the youth and is responsible for engaging in family/caregiver psychotherapy and service-related activities to benefit the youth.
    ii. The family/caregiver(s) must commit to participating in ≥ 30 minutes of CPST covered service components a week.
b. Active participation by school team in treatment planning and implementation
c. Family/caregiver(s) commitment to collaborative approach and treatment engagement

7.2 Tier Two CPST-School Setting Admission Criteria

1. **Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime) Requirements**
    a. Individual must be assessed using the CANS Lifetime tool within 30 days prior to admission.
    b. At least two CANS Lifetime domains scoring ≥ three (actionable needs requiring intervention)
    c. The level of need for the individual must be assessed at a level of need four or greater on the CANS Lifetime.
    d. Assessment must document specific functional deficits requiring community-based psychiatric support and treatment.

2. **Diagnostic Criteria:** must meet a and b
    a. The individual meets criteria for a primary ICD diagnosis that correlates to a DSM diagnosis and
    b. Individual meets criteria for an Early Serious Mental Illness, Serious Mental Illness or Serious Emotional Disturbance.
    c. Individuals may also have a co-occurring diagnosis of a substance use disorder or developmental disability.

3. **Functional Impairment Criteria: must meet a and b and at least two (level of need four) or three (level of need five) or all four (level of need 6) additional domains (c-f).**
The individual is unable to maintain an adequate level of functioning without CPST due to a mental illness as evidenced by significant impairment in functioning.
    a. Symptom Management – Documentation submitted by the provider must indicate that the individual exhibits significant impairment in the ability to manage symptoms of mental illness. Examples of significant impairment include, but are not limited to:
        i. Mental health symptoms significantly interfere with everyday activities and responsibilities
        ii. Has limited understanding of their symptoms and struggles to develop effective management strategies
        iii. Regularly experiences mental health crises requiring intervention
        iv. Symptoms cause significant distress and impair multiple areas of life functioning
        v. Has limited coping skills that are inconsistently effective or not regularly utilized
        vi. Infrequently uses healthy coping strategies and often relies on unhelpful or potentially harmful ways of managing stress

vii. Has great difficulty functioning when daily routines change and becomes very distressed in new or unfamiliar situations

b. Academic/Educational Functioning - Documentation submitted by the provider must indicate that the individual exhibits significant impairment in the ability to manage symptoms of mental illness. Examples of significant impairment include, but are not limited to:
    i. Declining academic performance or chronic academic underachievement
    ii. Frequent school absences or tardiness related to mental health symptoms
    iii. Difficulty completing assignments or participating in classroom activities
    iv. Problems with attention, concentration, or memory affecting learning
    v. Need for special education services or accommodations due to emotional/behavioral needs

In addition to meeting impairment in symptom management (a) and academic/educational functioning (b) above, level of need four requires that the individual meet at least two of the following (c-f).

In addition to meeting impairment in symptom management (a) and academic/educational functioning (b) above, level of need five requires that the individual meet at least three of the following (c-f).

In addition to meeting impairment in symptom management (a) and academic/educational functioning (b) above, level of need six requires that the individual meet all four of the following (c-f).

c. Social/Interpersonal Functioning
    i. Difficulty forming or maintaining peer relationships
    ii. Social withdrawal or isolation from classmates and school community
    iii. Conflicts with teachers, school staff, or authority figures
    iv. Inappropriate social behaviors that interfere with school participation
    v. Bullying behaviors (as perpetrator or victim) or social aggression
d. Emotional Regulation
    i. Frequent episodes of intense emotions in school setting
    ii. Difficulty managing anger, frustration, or anxiety in school setting
    iii. Panic attacks, flashbacks, or dissociative episodes during school hours
    iv. Intense and frequent mood lability affecting school performance and relationships
    v. Self-harm behaviors or suicidal ideation affecting school safety
e. Behavioral Functioning
    i. Disruptive classroom behaviors interfering with school setting
    ii. Aggression toward peers, staff, or property in school setting
    iii. School avoidance or refusal behaviors
    iv. Risky or impulsive behaviors compromising safety at school
    v. Violations of school rules requiring disciplinary action
f. Family/Caregiver Relationships
    i. Significant conflicts with family/caregivers affecting school performance
    ii. Family crisis or instability impacting youth's school functioning
    iii. Caregiver significantly struggles to support youth's educational needs due to mental health concerns
    iv. Family trauma requiring coordinated intervention

4. **Intensity of Service Criteria:** must meet both a and b
    a. Youth requires at least **four** services from the following:
        i. Individual therapy/counseling (minimum weekly)
        ii. Family therapy or caregiver support
        iii. Crisis support and safety planning
        iv. Care coordination between school, home, and community providers

v. Behavioral support and skill-building interventions
vi. Trauma-informed therapeutic interventions

b. The interventions necessary to stabilize the individual's behaviors, symptoms and ability to function requires the frequency, intensity and duration of contact provided by a Tier Two CPST-school setting provider as evidenced by clinical documentation meeting **all** of the following:
    i. Supporting the need for weekly intervention for seven or more hours per calendar month with a focus on skill building and school integration (hours are based on the level of need model) **and**
    ii. Supporting the need for intensive interventions in the school setting including:
        a. Real-time crisis coaching and de-escalation
        b. Environmental modifications and safety planning
        c. Intensive behavioral modeling and scaffolding
        d. Coordination with multiple service providers (psychiatry, case management, crisis services)

5. **School-Setting Need Indicators:** must meet at least **one** criteria and provide documentation of the need
    a. Referral from school team due to concerns about academic or social functioning that includes documentation of specific behavioral health related concerns and goals **or**
    b. Current IEP or 504 Plan with goals related to behavioral/emotional functioning

6. **Additional CPST-School Setting criteria:** must meet **all** criteria

There must be:

a. An identified caregiver(s) or legally authorized representative available and willing to participate.
    i. The caregiver(s) shall be a responsible adult who lives in the same household with the youth and is responsible for engaging in family/caregiver psychotherapy and service-related activities to benefit the youth.
    ii. The family/caregiver(s) must commit to participating in ≥ 30 minutes of CPST covered service components a week.
b. Active participation by school team in treatment planning and implementation
c. Family/caregiver(s) commitment to collaborative approach and treatment engagement

7.3 Continued Stay Criteria

CPST is a recovery-oriented intervention. If the individual is not making significant progress after 90 calendar days, then the provider and health plan must develop an alternative Individual Service Plan.

In order to meet continued stay criteria, **all** of the following must be met:

1. The youth continues to meet admission criteria.
2. Recovery requires a continuation of these services.
3. The youth and family/caregiver (as included in the ISP) are making progress toward goals and actively participating in the interventions. In the instance of limited or no progress, there must be documented evidence of changes in the ISP, efforts to engage the youth and family, or some other action to address the lack of progress.
4. There is a reasonable likelihood of continued substantial benefit as a result of active continuation of the services, as demonstrated by objective behavioral/functional measurements of improvement.
    a. Youth must be expected to improve and or recover at this current level of service, and
    b. The youth has not yet achieved the maximum benefit at the requested service

7.4 Discharge Criteria

Recommended duration of services is four to twelve months depending upon the assessed needs of the individual. Discharge is expected once the individual has met the following:

1. The youth no longer meets admission criteria OR
2. The youth has successfully met the specific goals outlined in the treatment plan for discharge; OR
3. Youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR
4. The youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies OR
5. The youth and/or family/caregiver(s) no longer need this service as they are obtaining a similar benefit through other services and resources.

8. Exclusions and Service Limitations

In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:

1. The following are not reimbursable:
    a. Services not in compliance with the Mental Health Services Manual may not be billed to Medicaid.
    b. The provider must ensure that treatment is the active delivery of an intervention identified on an individual's treatment plan. Passive observation of an individual without an intervention is not a billable activity.
    c. Completion of paperwork when the individual and/or their family/caregiver are not present is not reimbursable.
    d. Requiring the individual to be present to complete documentation in order to bill for services is not permitted or reimbursable.
    e. Team meetings and collaboration exclusively with staff employed or contracted by the provider where the individual and/or their family/caregiver are not present.
    f. Team member research on behalf of the individual;
    g. Providers may not set up summer camps and bill the time as a mental health rehabilitation service;
2. Admission and Concurrent Services Limitations:
    a. Individuals with a diagnosis of a developmental disability without a co-occurring mental illness diagnosis are not eligible for this service
    b. Comprehensive Crisis and Transition Services:
        i. The CPST provider or any affiliated provider or business of the CPST provider shall not provide Mobile Crisis Response, 23-Hour Crisis Stabilization or Residential Crisis Stabilization to any individual receiving CPST.
    c. Individuals that meet the admission criteria for Multisystemic Therapy, Functional Family Therapy Assertive Community Treatment or Coordinated Specialty Care are not eligible to receive CPST.
        i. Early Periodic Screening Diagnostic and Treatment policies apply as well as exceptions if the MCO/FFS service authorization contractor determine CPST is the appropriate service.
    d. Individuals receiving CPST may not receive the following services:
        i. Applied Behavior Analysis,
        ii. Addiction and Recovery and Treatment Services (ARTS) Levels: ASAM 2.1-3.7
        iii. Assertive Community Treatment,
        iv. Clubhouse Model of Psychosocial Rehabilitation,
        v. Coordinated Specialty Care,
        vi. Community Stabilization,
        vii. Functional Family Therapy,
        viii. Mental Health Partial Hospitalization Program,
        ix. Mental Health Intensive Outpatient,
        x. Multisystemic Therapy,
        xi. Psychiatric Residential Treatment Facility (PRTF) or
        xii. Therapeutic Group Home (TGH) services.
        xiii. Short-term service authorization overlaps are allowable as approved by the FFS service authorization contractor or MCO during transitions from one service to another for care coordination and continuity of care.

e. The authorization of additional behavioral health services, not included in the list above is determined by the CANS Lifetime assessment/identified level of need in collaboration with the individual and their Managed Care Organization or FFS contractor.

3. Other Limitations:
   a. Group size is limited to a team member to individual ratio of one to six for youth.
   b. Covered service components provided in the provider's DBHDS licensed office location shall not exceed one hour a week (Sunday-Saturday) per individual and shall be for the benefit of the individual.
4. CPST Providers in a school setting shall not act in any capacity or take on any responsibility that would be considered the responsibility of school personnel including but not limited to:
   a. Youth supervision other than in the confounds of the CPST service components.
5. No individual non-licensed staff may bill more than 504 CPST units in any calendar month (across all agencies in which they are employed).

9. Service Authorization

Service authorization is required. Providers shall submit service authorization requests within one business day of admission for preservice service authorization requests and by the requested start date for concurrent stay requests. If submitted after the required time frame, the start date of authorization will be based on the date of receipt.

Prior to submitting a service authorization request, the LMHP in collaboration with the individual, family/caregiver, and CPST team members must request services based on each individual's CANS Lifetime assessment/reassessment, treatment history, individual service plan, progress toward accomplishing goals/objectives, level of individual/family/caregiver engagement, individual choice/preference and level of need. The intensity, frequency, and duration for any requested service must be individualized.

The decision regarding the most effective service within a Level of Need is based on an individual's assessed needs, availability of treating providers in the individual's geographic area, individual preference, and other factors including an individual's readiness for change and individual/family/caregiver level of engagement. Interventions recommended must not be limited to the services delivered by the provider or provider agency conducting the assessment and submitting the authorization request. The individual's MCO/FFS service authorization contractor conducting the service authorization review may approve the requested service(s) or may recommend a more clinically appropriate service based on their review.

Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes is located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/. Information regarding our FFS service authorization contractor can be found here: Service Authorizations Home (Acentra Health/DMAS) | MES

9.1 Level of Need:

Service Authorization Requests must not exceed the following:

Level of Need	Service Type/Tier	SA Timeframe	Units (15 mins)	Minimum Service Required	Maximum Limit	Average hours per week	Average hours per month
2	CPST Tier One	180 calendar days	27 units per 30 calendar days	3 hours per month	6.75 hours per month	1-1.5	4-6
3	CPST Tier One	180 calendar days	35 units per 30 calendar days	7 hours per month	8.75 hours per month	1.75-2	7-8

Level of Need	Service Type/Tier	SA Timeframe	Units (15 mins)	Minimum Service Required	Maximum Limit	Average hours per week	Average hours per month
4	CPST Tier Two	180 calendar days	79 units per 30 calendar days	9 hours per month	Up to 19.75 hours per month	4-4.75	16-19
5	CPST Tier Two	180 calendar days	95 units per 30 calendar days	20 hours per month	Up to 23.75 per month	5-5.75	20-23
6	CPST Tier Two	180 calendar days	112 units per 30 calendar days	24 hours per month	Up to 28 hours per month	6-7	24-28

9.2 Preservice Authorization

The following information must be submitted with the preservice authorization request:

1. Complete service authorization request form
2. Initial Assessment including the completed CANS Lifetime
3. Initial ISP
    a. Must specify evidence-based practice used in treatment.
    b. Must include plan for telemedicine as described in the ISP section of Chapter IV, if applicable.

9.3 Concurrent Authorization

The following information must be submitted with the concurrent authorization request

1. Completed service authorization request form
2. Current addendum to the initial assessment (can be a progress note) that describes any new information impacting care, progress and interventions to date, a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria.
3. Updated ISP:
    a. Must include plan for telemedicine as described in the ISP section of Chapter IV, if applicable.
    b. Youth: Following initial authorization, if an individual is not progressing and the family/caregiver is not engaged or participating in treatment, the ISP must be updated to assure family/caregiver involvement before reauthorization is considered.
    c. Adults: Following initial authorization, if an individual is not progressing and/or engaged, the ISP must be updated to assure engagement and progress before reauthorization is considered.

10. Additional Documentation Requirements and Utilization Review

1. The progress note must clearly document that the services provided are related to the individual's goals, objectives and interventions in the treatment plan, and are medically necessary and clinically appropriate.
2. Each service/progress note must document the specific interventions delivered including a description of what materials were used when teaching a skill.
3. Service/progress notes must include:
    a. Each individual's response to the intervention, noting if progress is or is not being made.
    b. Observed behaviors if applicable and a plan for the next scheduled contact with the individual.
    c. Sufficient detail to support the length of the contact.
    d. The content must be specific enough so a third party will understand the purpose of the contact and supports the service and claims data.

e. The only team member who may complete a progress note is the team member who delivered the service. It is not permissible for one team member to deliver the service and another team member to document and/or sign the progress notes.

4. An LMHP must review documentation of non-licensed team members at least every 30 calendar days as evidenced by a progress note in the individual's chart written by the LMHP or a co-signature on the non-licensed team member's progress notes. Non-licensed team members include LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHPs, QMHP-Ts and BHTs.

Refer to Chapter VI of this manual for additional documentation and utilization review requirements.

11. CPST-School Setting Billing Requirements

Billing Code	Unit	Description	Notes	Provider Qualifications
H0036	15 minutes	CPST	Must be billed with modifier appropriate for staffing level associated with service component.	Service components must be provided by a qualified provider (see Provider qualification and staff requirements section).
H0031	Flat rate	CANS Lifetime		

Services must be billed with the modifier based on the team member level required for the service component:

Service Components	Team Member Type	Rate Unit	Procedure Code and Modifier Combination	Additional Information
Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime)	LMHP, LMHP-R, LMHP-S, LMHP-RP	Flat rate	H0031	
Treatment Planning	LMHP, LMHP-R, LMHP-S, LMHP-RP	Per 15 minutes	H0036, HO	
Treatment Planning, if assisting the LMHP	QMHP	Per 15 minutes	H0036, HN	
Psychotherapy	LMHP, LMHP-R, LMHP-S, LMHP-RP	Per 15 minutes	H0036, HO **or**	Individual
			H0036, HO, TJ	Group
Care Coordination	LMHP, LMHP-R, LMHP-S, LMHP-RP	Per 15 minutes	H0036, HO	
Care Coordination	QMHP	Per 15 minutes	H0036, HN	
Crisis Support	LMHP, LMHP-R, LMHP-S, LMHP-RP	Per 15 minutes	H0036, HO	
Crisis Support	QMHP	Per 15 minutes	H0036, HN	
Restorative Life Skills Training	All Restorative Life Skills Training, no matter the staff member providing the service.	Per 15 minutes	H0036, HN	Individual
			H0036, HN, TJ	Group
Rehabilitative Skills Practice	All Rehabilitative Skills Practice, no matter the staff member providing the service.	Per 15 minutes	H0036, HM	

1. A QMHP may provide BHT level services and must bill using the procedure code/Modifier combination associated with BHTs
2. An LMHP, LMHP-S, LMHP-R, or LMHP-RP may provide any component of CPST but must bill using the procedure code and modifier combination associated with the service component.
3. No individual non-licensed staff may bill more than 504 CPST units in any calendar month (across all agencies in which they are employed).